TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Hand and Wrist Center of Houston

Respondent Name
Amtrust Insurance Company of Kansas, Inc.

MFDR Tracking Number
M4-15-3160-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
May 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The submitted documentation does not include a position statement from the requestor.

Amount in Dispute: $343.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With regard to CPT code 99285, Respondent denied the payment for the office visit as it is not payable separately. When the decision to perform a minor procedure is done immediately before the procedure, the office visit is considered a routine preoperative service and is not reimbursed in addition to the procedure. The procedure performed on 7/21/14 was a minor procedure, as known by its global status indicator of 000. Therefore, the office visit on the same day as the minor procedure is considered global and does not warrant separate reimbursement."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2014	Evaluation & Managent, emergency department (99285)	$343.07	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 220 – The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 351 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code "97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Administrative Code §134.203 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Review of the submitted information finds that the dispute involves an emergency room visit, CPT Code 99285, resulting in the decision to perform a minor surgery, CPT Code 11012, performed the same day. The Medicare Claims Processing Manual, Chapter 12 §40.1 states, "Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. The manual further defines minor surgeries as those with 000 or 010 global indicators. CPT Code 11012 has a global indicator of 000. Review of the submitted documentation does not support a significant, separately identifiable service performed with the disputed code. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 26, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.